Centre for Endometriosis and Minimally Invasive Gynaecology

Ashford and St. Peter's Hospitals NHS Foundation Trust

(For clinic use)
Clinic date: Consultant Seen by

This questionnaire has been designed to help us understand your problems and to find the most appropriate treatments. It may also help you to formulate your thoughts on your symptoms and the way in which they can affect your quality of life.
It is important that you answer as many of the questions as you are able. If you find any of them awkward to answer, please leave them blank and we may discuss them at your consultation should you wish.
Please be assured that the information you provide will be kept confidential, in accordance with Data Protection legislation.
If you do not understand any of the questions, particularly about previous treatment, or if parts of this questionnaire are not relevant to your problem, please leave these blank.

Full Name Date of Birth

Please do not write on the right side

E-mail

Marital status Occupation

What is the nature of the problem you wish to discuss?

Number of Pregnancies Number of Children Number of Miscarriages

If you have children, please list the year they were born and mode of delivery.

Are you

- ◯ Currently pregnant
- ◯ Trying for pregnancy for less than 18 months
- ◯ Trying for pregnancy for more than 18 months
- ◯ Not currently trying for pregnancy / Not applicable

Contraception (Current)

- [ ] None
- [ ] Trying for pregnancy
- [ ] Not sexually active
- [ ] The Pill
- [ ] Mini Pill
- [ ] Mirena Coil
- [ ] Copper Coil
- [ ] Condoms
- [ ] Implanon
- [ ] Sterilisation
- [ ] Vasectomy
- [ ] Had Hysterectomy

Contraception (past)

- [ ] Never used
- [ ] Never sexually active
- [ ] The Pill
- [ ] Mini Pill
- [ ] Mirena Coil
- [ ] Copper Coil
- [ ] Condoms
- [ ] Implanon
- [ ] Sterilisation
- [ ] Vasectomy
- [ ] Had Hysterectomy

Regarding your periods, choose one or more of the following options

- [ ] They are regular
- [ ] They are irregular
- [ ] I have spotting between periods
- [ ] They are not particularly heavy
- [ ] They are somewhat heavy
- [ ] They are very heavy
- [ ] I often need double protection
- [ ] The heaviness of my periods affect my quality of life
- [ ] I don't have periods because I have gone through menopause or had a hysterectomy
- [ ] I don't have periods but I have not gone through menopause

When was your last cervical smear?

Was this normal?

Have you ever had an abnormal smear?

Do you Smoke?

Your height (cm)

Weight (Kg)

Do you have any allergies?

Medications (Current)

- [ ] None
- [ ] Paracetamol
- [ ] NSAIDS (such as Ibuprofen, Diclofenac)
- [ ] Opiates (Tramadol)
- [ ] GnRH analogues (Zoladex, Lupron)
- [ ] Mirena Coil
- [ ] Progestogens (Provera, Duphaston)
- [ ] HRT
- [ ] Aromatase inhibitors
- [ ] Mirena coil
- [ ] Oral contraceptives
- [ ] Other

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- [ ] None
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- [ ] Other

Previous Surgery

- [ ] None
- [ ] Caesarean section
- [ ] Laparoscopy
- [ ] Hysterectomy
- [ ] Removal of ovaries
- [ ] Sterilisation
- [ ] Hysteroscopy
- [ ] Vaginal surgery
- [ ] Other

If you have had any previous surgery, please provide more details below (with approximate dates and hospital)

Full name
(again please)

Do you have any significant or long-term condition

Is there any history of significant diseases, such as cancer in your family?

Over the course of your **current normal menstrual cycle**, which of the following symptoms do you experience? If you have experienced the symptom, circle a score from 1 to 10 to indicate how slight or severe it usually is. N/A denotes 'no period')

Pain scores
1 = experienced slightly, 10 = experienced severely

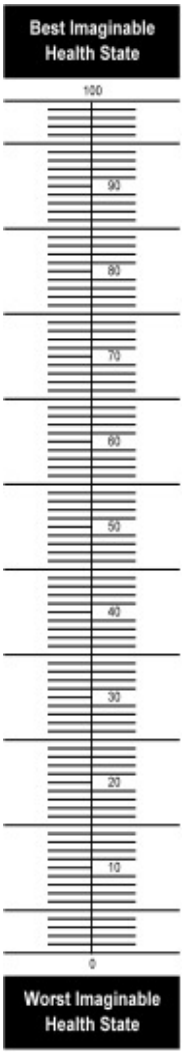
	N/A	None	1	2	3	4	5	6	7	8	9	10
Premenstrual pain (pain before periods)	○	○	○	○	○	○	○	○	○	○	○	○
Menstrual pain (pain during periods)	○	○	○	○	○	○	○	○	○	○	○	○
Non-cyclical pelvic pain (pain throughout the month)	○	○	○	○	○	○	○	○	○	○	○	○
Pain during sexual intercourse	○	○	○	○	○	○	○	○	○	○	○	○
Pain opening bowels during period	○	○	○	○	○	○	○	○	○	○	○	○
Pain opening bowels at other times	○	○	○	○	○	○	○	○	○	○	○	○
Lower back pain	○	○	○	○	○	○	○	○	○	○	○	○
Bladder pain or pain passing urine	○	○	○	○	○	○	○	○	○	○	○	○
Do you have difficulty emptying your bladder?	○	○	○	○	○	○	○	○	○	○	○	○

Your bowel function

	N/A	Never	A little of the time	Some of the time	Most of the time	All of the time
Do you have frequent bowel movements?	○	○	○	○	○	○
Do you have urgent bowel movements?	○	○	○	○	○	○
Do you have sensation on incomplete emptying of the bowel?	○	○	○	○	○	○
Do you have constipation?	○	○	○	○	○	○
Have you been troubled by blood in the stool around the same time as your period?	○	○	○	○	○	○

The following questions refer to how you feel about your health in general TODAY. They form part of a standard set of questions relating to quality of life and therefore some may not seem particularly relevant to you. However, please try to answer ALL questions.
Please score how good or bad your health is TODAY. The best health state you can imagine is marked 100 and the worst health state you can imagine is marked 0.

Based on the above paragraph and looking at the scale below, how would you score your health today? (0-100)



Please do not write in this box

Usual Activities (e.g. work, study, housework, family or leisure activities)

- ◯ I have no problems with performing my usual activities
- ◯ I have some problems with performing my usual activities
- ◯ I am unable to perform my usual activities

Pain/Discomfort

- ◯ I have no pain or discomfort
- ◯ I have moderate pain or discomfort
- ◯ I have extreme pain or discomfort

Anxiety/Depression

- ◯ I am not anxious or depressed
- ◯ I am moderately anxious or depressed
- ◯ I am extremely anxious or depressed

Mobility

- ◯ I have no problems in walking about
- ◯ I have some problems in walking about
- ◯ I am confined to bed

Self-Care

- ◯ Self-Care
- ◯ I have some problems washing or dressing myself
- ◯ I am unable to wash or dress myself

Please do not write on this page

Plan (For clinic use)

Doctor's signature and date (For clinic use)